Official use only- Region _____

New Hampshire Department of Safety - Bureau of Emergency Medical Services

Automated External Defibrillation Request Form

Entity for which the unit is being requested: _____

Type of Entity: Business, Municipality, Store, other please specify _____

Contact person and title within the entity: _____

Phone Number: _____ Fax: _____

Mailing Address: _____

_____

E-mail address: _____

Person requesting: _____ / _____

(Name) (Agency/Organization)

Requesting person's contact information: ____Same as above, or:

Phone number: _____ E-mail : _____

Number of AED's being requested: _____

Reason for request: _____

_____

_____

Does the entity currently have an AED or Cardiac Monitor? YES / NO

Is the entity able to accept financial responsibility for the AED? YES / NO
(i.e. Maintenance, extra pads, batteries)

Street address where machine will be located: _____

City/Town_____State_____Zip_____

Where, at the above location, would the AED be stored? _____

_____

Is there anyone currently trained in CPR / AED? YES / NO

Number of AED Providers_____

Signature:_____Date:_____

Please complete and return to:

Department of Safety
Division of Fire Standards and Training & Emergency Medical Services
Bureau of Emergency Medical Services
33 Hazen Drive Concord NH, 03305 or Fax to: 603-271-4567 Attn: Bill Wood